

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER SWEET LIFE AT BROOKDALE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 224 SS=J	<p>The following citations represent the findings of a Partial Extended Survey and Complaint Investigation KS#71763.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: The facility's census totaled 91 residents with 3 sampled. Based on observation, interview and record review, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) for 1 sampled resident (#1) found unresponsive and this failure placed the resident in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The admission Minimum Data Set 3.0 (MDS) for resident #1 dated 12/6/13 documented the Brief Interview for Mental Status score of 14 which indicated the resident's cognitive status was intact. The MDS further documented the resident required extensive assistance of 1 staff with toilet use, and limited assistance of 1 staff with bed mobility, transfers, locomotion on the unit, dressing and personal hygiene. The resident 	F 224			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER SWEET LIFE AT BROOKDALE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 224	<p>Continued From page 1 expected to be discharged to the community.</p> <p>The revised care plan dated 12/12/13 documented interventions which included the staff would conduct a weekly interdisciplinary meeting to discuss the progress with therapy, medical situation, and nutritional needs. The resident was monitored by a nurse on a daily basis. The resident's needs were communicated to the nursing staff by the nurse's jot sheets and certified nurse aides jot sheets.</p> <p>Review of the clinical record revealed a Code Status Sheet/Advanced Medical Directive form dated 11/29/13 which indicated the resident was a Full Code (provide all services needed to keep a person alive).</p> <p>The Physician Order Sheet (POS) dated 1/3/14 documented the resident's Code Status: Full which indicated the resident wanted all services needed to keep a person alive.</p> <p>The untimed nurse's note documented on 1/2/14 revealed the resident's cognition was alert and the resident had no problems with speech, behaviors, skin, cardiovascular, respiratory, or pain.</p> <p>The nurse's note documented on 1/3/14 and timed 1:00 A.M. revealed the resident was in bed, denied pain, and had no shortness of breath (SOB) at this time.</p> <p>The nurse's note documented on 1/3/14 at 4:00 A.M. the resident was found to be unresponsive by an aide. The licensed nursing staff H documented, the resident had an absence of a pulse and cold bilateral lower extremities. The</p>	F 224			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER SWEET LIFE AT BROOKDALE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 224	<p>Continued From page 2</p> <p>licensed nursing staff I verified with licensed nursing staff I the resident had no pulse or signs of life. The licensed nursing staff notified the physician and received an order to release the body to a mortuary.</p> <p>Licensed nursing staff H's notarized statement documented on 1/4/14 around 4:00 A.M. the certified nurse's aide reported something was wrong with the resident because he/she would not wake up. The lights were on in the room when licensed nursing staff H entered to assess the resident and he/she could tell the resident had no signs of life. Licensed nursing staff H checked the resident's wrist and neck to check for a pulse and did not feel a pulse. The resident felt cold to touch from the waist down but the resident's torso was warm. Licensed nursing staff H called licensed nursing staff I to assess the resident for pulses as well. Both nurses went to the nurses' station and the resident's chart revealed the resident was a full code. Licensed nursing staff H asked licensed nursing staff I what should we do now since we found the resident with no pulse. Licensed nursing staff I stated for the nurse to call the resident's doctor. Licensed nurse H called the doctor and explained the resident was found with no signs of life. Licensed nursing staff stated he/she asked the doctor what the nursing staff should do. The doctor asked what the resident's admitting diagnosis was and then asked if the resident was on hospice services. Licensed nursing staff H stated he/she was waiting for the doctor to say to start CPR on the resident and the doctor said to release the body to the mortician.</p> <p>Licensed nursing staff I's notarized statement revealed on 1/4/14 (untimed) he/she assessed the resident with licensed nursing staff H and the</p>	F 224			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER SWEET LIFE AT BROOKDALE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 224	<p>Continued From page 3</p> <p>resident was cold to touch. Licensed nursing staff I revealed the nursing staff did not try to resuscitate the resident because he/she had been gone for a long time.</p> <p>On 1/31/14 at 11:30 A.M. administrative nursing staff D revealed the nursing staff involved did not follow the facility's policy of starting CPR when the resident was found without vital signs. The nursing staff also did not tell the doctor the resident's code status. The residents' information and code status was written on the nurses' jot sheet which contained information about each resident's needs and their code status.</p> <p>On 2/6/14 at 9:55 A.M. administrative nursing staff D revealed the facility staff were in-serviced on the CPR policy on the date of hire and annually.</p> <p>The revised April 2011 facility's policy "Emergency Procedure- Cardiopulmonary Resuscitation (CPR)" documented if an individual (resident, visitor, or staff member) was found unresponsive and not breathing normally, a licensed staff member who was certified in CPR shall initiate CPR unless it was known that a Do Not Resuscitate (DNR) order that specifically prohibited CPR and/or external defibrillation existed for that individual.</p> <p>The facility failed to ensure the nursing staff provided resident #1 with CPR as he/she requested when he/she entered the building, which placed this resident in immediate jeopardy.</p> <p>The facility abated this immediate jeopardy on 2/8/14 at 6:30 P.M. when:</p> <p>1. The facility in-serviced the licensed nurses on</p>	F 224			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER SWEET LIFE AT BROOKDALE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 224	<p>Continued From page 4</p> <p>what to do when findings someone unresponsive and how to "run a code."</p> <p>2. In-serviced the staff on the CPR policy and procedure.</p> <p>3. All staff in-serviced regarding Effective Emergency Communication.</p> <p>4. In-serviced staff on the use of the Automated External Defibrillators (AED)/CPR.</p> <p>5. Training of all new staff upon hire regarding first aide and what to do when finding someone not breathing.</p> <p>6. Nurse Orientation Checklist to include instruction regarding code status, Advanced Directives, and running a code.</p> <p>7. Mock code to involve nurses on all shifts.</p> <p>This deficient practice remains at a scope and severity of a D.</p>	F 224			